Waiting List Management Advisory Team

Response to Senate Bill 266

Final Report

Submitted to:

Dr. Anne S. Deaton, Director
Division of MRDD

11/1/03

Table of Contents

PAGE

INTRODUCTION AND OVERVIEW

INTRODUCTION

Anne Deaton, Ed.D, Director of the Division of MRDD, charged the Waiting List MAT (Management Advisory Team) to develop a plan in response to the requirements of SB 266, a bill passed in 2003 to eliminate existing wait lists for services in the Division and to reduce wait time to no more than 90 days for new requests.

The Waiting list MAT includes a wide cross section of individuals representing various interests, support and advocacy groups. Representatives for People First, the Personal Independence Commission (PIC), Paraquad, the Missouri Planning Council for Developmental Disabilities, Missouri Association of County Developmental Disabilities Services (MACDDS), Missouri-American Network of Community Options and Resources (MO-ANCOR), Missouri Association of Rehabilitation Facilities, and parents, as well as Division staff, met on a regular basis from April 2003 up to the completion of this report in September 2003.

Submission of this report to Anne Deaton, Division Director, in September, 2003 will then result in its eventual submission to the Governor, Speaker of the House, and President Pro Tem of the Senate. This is considered a first step in the work that needs to be done to accomplish the goals of SB 266. All involved consider this endeavor to be one of the most important and timely initiatives that will have a great impact on the future of services for people with developmental disabilities.

This report responds to the key components in SB 266. It is fortunate that some of the procedures are already in place. For example, we feel that we have a strong person-centered plan process for the identification of needs and for supporting needs for each person entering the system. We also feel that the division's Utilization Review process, in effect for over a year now, is a productive process helping us to identify need and to prioritize requests for services.

Perhaps the most difficult component is the development of the budget requests to meet the needs of SB 266 over the course of five years. The existing wait lists and projected costs of services over the next five years can be calculated. However, this plan requires the projection of new admissions to the Division, projections of people transitioning from high school, projections on the number of aging families who will be requesting services for their family member, and projections on the number of persons who will require emergency services, and the costs for those services. A complicating factor in this process is the instability of the state budget. Although SB 266 does not require a budget request or projection, the availability of funding is the single most important factor in expanding services and moving off a wait list. The Division plan includes a financial projection of the funding needed to achieve the goals of SB 266.

Issue 1: A Method to Reduce the Waitlist

Senate Bill Number 266
633.032 (1) (1) A method to reduce the waitlist for services over a period of five years to reduce the waiting period to ninety days.

I. Develop a funding stream through new appropriations

This year the Division of Mental Retardation and Developmental Disabilities (DMRDD) received a $5,070,314 appropriation for caseload growth to address the residential wait list. This funding will provide the state share necessary to meet the needs of over 230 individuals who are Medicaid eligible out of 641 individuals on wait lists. These funds will primarily be used for residential services, but may also fund in home services if those services would prevent out of home placement. The continuation of Medicaid caseload growth funding in future DMRDD appropriations is essential in order for existing wait lists to be eliminated and to assure access to services within 90 days.

In order to meet the needs for those individuals who are *not* Medicaid-eligible, additional General Revenue appropriation will also be required.

See Appendix II-1 for details, p.34

II. What we are doing now

a. Utilize Waivers to enhance our funding

On July 1, 2003, the Division received approval from Medicaid to operate a new waiver, the Community Support Waiver. Initially, the targeted population is persons receiving services funded by state General Revenue only. Many of these people receive moderate cost services and with entry into this waiver, the division can save approximately 60% of the cost for services. We anticipated that we could have redirected $2.4 million to address the wait list, however, those resources were needed to address other state budget issues. With a new appropriation, additional eligible people could be added to this waiver which has a maximum cap of $20,000 in services, requiring $8,000 state matching funds. This waiver also offers an opportunity to county SB 40 boards to use their public funds to access Medicaid which results in a 60% savings on the cost they would otherwise incur. These savings can be redirected to fund additional services.

b. Expand relationships with county SB 40 Boards

We have expanded our relationships with county boards through the community support waiver mentioned above.

Also, approved counties provide case management that can be billed to Medicaid as Targeted Case Management. This increases the availability of case management services, gives consumers choice of case management between the county and the State, and it generates additional federal funds that can be applied to new services. There are 13 counties (Boone, Cole, Cooper, Franklin, Jasper, Jefferson, Platte, Miller, Pike, Pettis, Saline, St. Francois, St. Louis City) currently providing case management and several others are pending.

c. Reduce the wait list through attrition

In the FY '03, the division provided residential services to 205 new individuals on an emergency basis only. Funds for these services come through attrition or through the redirection of other funds. Still, these efforts have little impact on wait lists because of the rate of growth.

Issue 2: A Description of Minimum Supports and Services

Senate Bill Number 266
633.032 (1) (2) A description of minimum supports and services available to all eligible individuals and their families.

I. Evaluation/Intake

Every person who requests services from the Missouri Department of Mental Health, Division of Mental Retardation and Developmental Disabilities, is entitled to an evaluation to determine if s/he is eligible for services as per 9 CSR 45-2.010. To receive services through the division, a person must have mental retardation or some other developmental disability. According to 630.005, RSMo, a qualifying individual's mental retardation must have occurred before age 18, while any other developmental disability must have occurred before age 22. All conditions must be expected to continue indefinitely.

II. Case Management

Case management (a.k.a. service coordination) assists individuals to gain access to the support and services they need. Case management activities include:

- ✓ assessment or identification of need for services and supports;
- ✓ planning services to meet identified need;
- ✓ coordinating the services identified as necessary to meet a need;
- ✓ monitoring the outcome of services being provided to determine if they are appropriate and adequate and are meeting the need as intended; and
- ✓ documenting services provided, progress being made with the services, changes in need, etc.

III. Person-Centered Plan

Within 30 days of being determined eligible for services, and annually thereafter, every person is entitled to a person-centered plan per 9 CSR 45-3.010.

The plan is developed in accordance with the DMRDD's Missouri Quality Outcomes Discussion Guide and the Service Coordination Manual. It is based on the case manager's functional assessment of the individual, all other assessments that are pertinent, and the observations and information gathered from the members of the team. The functional assessment determines how the individual wants to live, the individual's routines, what works for the individual and what does not. It also assesses what the individual wants to learn and how the individual learns best. The assessment measures how independently the individual functions, identifies barriers to the person's needs and wants, and suggests ways the individual's needs and wants can be met.

The plan specifies all the services and supports that are needed, and who is to provide them, to enable the individual to live the way the individual wants and learn what the individual wants to learn. Services may be provided directly by the division or purchased for the eligible person within the limits of the division's appropriation authority.

The planning team includes the individual and his or her representatives, family or guardian. The individual/family/guardian chooses who attends as a member of the team.

Issue 3: An Evaluation of Current Provider Capacity

Senate Bill Number 266
633.032 (1) (3) An evaluation of the capacity of current providers to serve more individuals.

A survey instrument was developed by members of the DMRDD Waiting List MAT. During the first week of August, 2003, the Provider Capacity Survey was sent out to DMRDD providers by the division's eleven regional centers. It is estimated that the survey was sent to 1,300 MRDD contract providers throughout the state. A total of 244 surveys (approximately 19%) were completed and returned. The survey asked providers to report their capacity to expand specific community services to new individuals, and also asked providers to identify significant barriers that would impact their ability to expand specific services. A summary of the survey results on capacity and barriers follows. The actual survey instrument and a summary of provider narrative comments are included in the Appendices.

Capacity

In response to the question of how many new individuals their organization could serve in the next five years, following is a summary of the total capacity providers reported:

	Total Response
Day Habilitation	1674
Personal Assistance	1063
Respite	1597
Residential/Community Living	1603
Employment	661
Transportation	404
Autism Services	231
Other	156

Barriers

If an organization was not willing to expand or develop any of the services listed, they were asked to rank the barriers. Providers were asked to assign a '1' to the most significant barrier, and so forth. 'NR' indicates the barrier was not ranked by any provider. Following are rankings of barriers for each service.

Day Habilitation

1	No Interest	5	Health Insurance Cost
2	Reimbursement Rates	6	Staff Training
3	Unable to Recruit Qualified Staff	7	Lack of Demand for the Service
4	Lack of Expertise	8	Transportation
5	Worker's Compensation Cost	9	Other

Personal Assistance

1	Reimbursement Rates	6	Staff Training
2	Worker's Compensation Cost	6	Transportation
3	Health Insurance Cost	7	Lack of Expertise
4	Lack of Demand for the Service	8	No Interest
5	Unable to Recruit Qualified Staff	9	Other

Respite (out of home)

1	Worker's Compensation Cost	5	Other
2	Unable to Recruit Qualified Staff	6	Reimbursement Rates
3	Health Insurance Cost	7	Staff Training
4	Lack of Demand for the Service	7	Transportation
5	No Interest	8	Lack of Expertise

Respite (in home)

1	No Interest	6	Staff Training
2	Reimbursement Rates	7	Lack of Demand for the Service
3	Unable to Recruit Qualified Staff	8	Transportation
4	Worker's Compensation Cost	9	Lack of Expertise
5	Health Insurance Cost	10	Other

Residential/Community Living

1	Reimbursement Rates	6	Lack of Demand for the Service
2	Health Insurance Cost	7	Staff Training
3	Worker's Compensation Cost	8	Transportation
4	Unable to Recruit Qualified Staff	9	Lack of Expertise
5	Other	10	No Interest

Employment

1	Unable to Recruit Qualified Staff	6	Transportation
2	Staff Training	NR	No Interest
3	Reimbursement Rates	NR	Lack of Expertise
4	Other	NR	Lack of Demand for the Service
5	Worker's Compensation Cost	NR	Health Insurance Cost

Transportation

1	Health Insurance Cost	NR	Lack of Demand for the Service
2	Worker's Compensation Cost	NR	Unable to Recruit Qualified Staff
3	Reimbursement Rates	NR	Staff Training
NR	No Interest	NR	Transportation
NR	Lack of Expertise	NR	Other

Autism

1	Lack of Expertise	NR	Worker's Compensation Cost
2	Reimbursement Rates	NR	Staff Training
NR	No Interest	NR	Transportation
NR	Lack of Demand for the Service	NR	Other
NR	Unable to Recruit Qualified Staff	NR	Health Insurance Cost

Other

NR	No Interest	NR	Staff Training
NR	Lack of Expertise	NR	Reimbursement Rates
NR	Lack of Demand for the Service	NR	Transportation
NR	Unable to Recruit Qualified Staff	NR	Other
NR	Worker's Compensation Cost	NR	Health Insurance Cost

Summary of Provider Ranking of Barriers

	BARRIERS									
SERVICES	Reimbursed Rates	Unable to Recruit Qualified Staff	Health Ins. Cost	Worker Comp. Cost	No Interest	Lack of Demand for Service	Staff Training	Lack of Expertise	Other	Transp
Day Habilitation	2	3	5	5	1	7	6	4	9	8
Personal Assistant	1	5	3	2	8	4	6	7	9	6
Out of Home Respite	6	2	3	1	5	4	7	8	5	7
In Home Respite	2	3	5	4	1	7	6	9	10	8
Residential	1	4	2	3	10	6	7	9	5	8
Employment	3	1	NR	5	NR	NR	2	NR	4	6
Transportation	3	NR	1	2	NR	NR	NR	NR	NR	NR
Autism	2	NR	NR	NR	NR	NR	NR	1	NR	NR
Other	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Total 1-3	14	9	9	8	2	0	2	1	0	0
Total 4-10	6	9	10	14	23	28	32	37	42	43
Barrier Ranking	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10

NR=No Ranking

An analysis of the rankings assigned to the various barriers indicates providers reported reimbursement rates as the greatest barrier to their ability to expand. The second greatest barrier indicated by providers was the ability to recruit qualified staff and the third greatest barrier reported was the cost of insurance, followed by the cost of worker compensation insurance.
See Appendix II-3 for details, p.37

Issue 4: A Method of Adjusting Service and Support Levels

Senate Bill Number 266
633.032 (1) (4) A method of adjusting support and service levels based on the needs of the eligible individual combined with family or other relevant circumstances affecting the support of such individual.

Person Centered Planning

Annually, a person centered plan is developed in accordance with the DMRDD's Missouri Quality Outcomes Discussion Guide and the Service Coordination Manual. The individual and his/her family or guardian, the service coordinator (case manager), and any other individuals the individual requests, are members of the planning team. The plan is based on a functional assessment of the individual which includes input from all team members. The assessment determines how the individual wants to live, the individual's routines, what works for the individual and what does not. It measures how independently the individual functions and what may interfere with the individual's plan, and it suggest ways the individual's needs and wants can be met.

The plan specifies all the services and supports that are needed, and who is to provide them. The individual chooses from eligible providers, the provider that will deliver services in his/her plan.

The service coordinator monitors the plan at least quarterly to ensure the plan still addresses the needs of the individual. During service monitoring, case managers document whether the outcomes stated in the person's plan are occurring and whether the outcome set forth by quality outcomes are consistent with the person's choices and support needs. The provider's progress notes are also reviewed at least quarterly. If the service coordinator notes any problems, discrepancies, dramatic changes or other occurrence which would indicate a need for renewed assessment or change in level or type of service the plan may be changed with an amendment.

Plans may be amended any time throughout the year to reflect changes in need or to adjust the level or type of service necessary to more appropriately meet a need. Planning team members, including the individual and family, are consulted for input before a plan is amended.

Utilization Review

All initial plans are subject to utilization review. Plans that request substantial increases in services are also subject to utilization review. Plan reviews and utilization review take place to determine the appropriateness and adequacy of the services and to ensure that the services furnished meet the needs and choices of the person.

The purpose of the utilization review/approval process is to:
- ✓ Enhance quality of services and the service delivery system
- ✓ Ensure fairness and consistency statewide
- ✓ Ensure accountability for taxpayer dollars, and
- ✓ Stretch limited MRDD resources

See Appendix II-4 for details, p.47

Issue 5: A Method for Determining Circumstances when Out-of-Home, 24 Hour Care is Necessary

Senate Bill Number 266
633.032 (1) (5) A method for determining the circumstances when out-of-home 24 hour care may be necessary.

Twenty-four hour support is necessary when the following emergency circumstances arise:

1) The person is in immediate need of life-sustaining services and there is no alternative to division funding or provision of those services. Life-sustaining service is defined as a service to meet a basic human need, such as food and shelter, or protection from harm, and it may include persons referred by the Division of Comprehensive Psychiatric Services with forensic status.
2) The person must be provided immediate services in order to protect another person or persons from imminent physical harm.
3) The person is the focus of a court order or imminent court order and the DMRDD is obligated to respond.

Twenty-four hour support is also considered when funding is available and the following circumstances arise:

1) Services are requested by the family or guardian for an adult who requires increasing levels of support they cannot provide in the home;
2) Services are requested by elderly or seriously ill caregivers;
3) Individual wants to move to a more integrated setting.

There are two mechanisms in place to determine when someone needs 24 hour support.

A. Utilization Review Prioritization of Need (See Appendix)
B. Emergency Waiver Slot Assignment (See Appendix)

In both situations the need for 24 hour support must be determined and must meet the following criteria:

Person-centered plan driven
Priority of need driven (part of the UR process)
Utilization Review approved. The Utilization Review Process will not interfere with the person's need to receive immediate, emergency services.

After consumers meet the criteria for emergency or non-emergency 24 hour support then appropriate residential services are selected. In non-emergency situations, the person's name is placed on the residential wait list according to the score received on the UR prioritization of need scale. Other non-residential support services, subject to appropriation, may be made available while on the wait list.

See Appendix II-5 for details, p.57

Issue 6: A Description of How the Plan Will be Implemented Statewide

Senate Bill Number 266
633.032 (1) (6) A description of how the plan will be implemented on a statewide basis.

The Division is confident in our person-centered plan process and in the ability of our regional centers and county board partners to work with individuals, families, and providers to identify needed services and to write appropriate plans with people. The development of the Person-Centered Plan is one of the cornerstones for implementation of this plan.

We are also confident in our Utilization Review of new plans and annual plans. Services provided should have positive benefits and outcomes to the consumer. In August of 2003 we began a statewide reassessment of our Utilization Review Process to ensure it is meeting the goals for which it was originally intended. If necessary, we will make changes to the process and train staff on a statewide basis to ensure consistency.

We already have a process in place that allows individuals and families to hire, train, and supervise their own personal assistant workers using a fiscal intermediary. We have applied for an Independence Plus Grant. If the grant is approved, DMRDD will conduct pilots to determine the feasibility of expanding other components of self direction when doing so would be both beneficial to consumers and cost-effective.

As Missouri moves forward in addressing the wait lists for people with developmental disabilities, we must protect individual rights by striving for self-determination whereby systems are structured so that service recipients influence policy and individuals have the freedom and authority to determine the substance and texture of their own lives, including control over the resources allocated for personal services or supports.

Self-determination is defined as:
To act as the principal causal instrument in one's life and to make choices and decisions regarding one's chosen lifestyle independent of undue influence or interference from others.

Wehmeyer, Kelchener, & Richards (1996). In the American Journal on Mental Retardation, 100(6), 63-642.

Self-determination and a person's right to self-direct are core values that must be addressed in any plan to provide services for Missourians with developmental disabilities. The following principals should guide Missouri's service system:

- People with developmental disabilities and family members have options in all areas of services and supports.
- People with developmental disabilities are informed of the variety of options, as well as the benefits and risks associated with the choices they make.
- People with developmental disabilities have the opportunity, with support as needed from those who care about them, to make choices and decisions about their every day lives.

- Individuals exercise responsible control over their allocated resources.
- People with developmental disabilities can modify services and supports to accommodate their changing needs.

(Adapted from the Missouri Planning Council for Developmental Disabilities, Show Me Change, 1998)

When defining self-determination, there is a need to assure that individuals with disabilities and their families have the opportunity to be the decision makers concerning the supports that are needed and how they can best be provided. Participant-driven approaches to system reform require that people and families rather than third parties exercise choice over how dollars are used (within certain parameters); that supports be obtained within a fixed dollar budget; and that the person and their family carries some amount of risk if the budget is improperly used.
(John Agosta, 2003)

The Division is committed to meeting the most urgent needs of consumers across the state. The FY 04 case load growth funds were distributed to Regional Centers according to specific consumers with the greatest need as determined by the Utilization Review process.

We plan to utilize this same method for caseload growth and community support funding in future years. This method distributes funding where it is most needed.

Issue 7: Changes in State Law Required to Implement the Plan

Senate Bill Number 266
633.032 (1) (7) Any Changes in state law that will be required to implement the plan.

No changes in state law are required to implement this plan; however, the long term care and supports system could be improved if funding were more flexible and able to follow a person to a preferred setting. Sometimes, individual choice is limited because department budgets are fixed and inflexible. Missouri does have flexibility language in the Department of Social Services budget (HB 11) and there is flexibility in the Department of Mental Health budget line item for habilitation centers. There are barriers, however, to achieving the full intent of the "money follows the person" concept. For example, money does not follow from the nursing home budget to the Division of MRDD community services budget. Additionally, Individuals do not have the option to "pool" all of their community services dollars from various state agencies and spend it all on the service of their choice.

A number of states have made some changes in their financing systems in order to support individual choice. Texas passed legislation which created linkages between budget categories so that as a person moves from one service/setting to another, the money actually moves from one budget to another. Some states, such as Michigan, have combined funding from different Medicaid services into one flexible funding source that people can access regardless of which setting/service they choose. A number of states are increasing both funding flexibility and consumer control through the use of individualized, self-directed budgets. These programs promote money following the person because the individual can choose which services she or he wishes to purchase. Missouri can remove the barriers to money following the person by passing legislation that allows money to move from one budget category to another and by implementing options such as individualized, self-directed budgets.

Issue 8: An Analysis of Budgetary and Programmatic Effects of Providing Supports/Services for All Eligible Individuals

Senate Bill Number 266
633.032 (1) (8) An analysis of the budgetary and programmatic effects of providing supports and services for all eligible individuals and their families.

The benefits of making resources available within 90 days of a consumer being placed on the waiting list include:

1. Families and consumers will be able to access the services they need when they need them and not be required to have an emergency before services can be authorized.
2. Consumers with the appropriate support services will be able to stay connected with their families and remain in their communities as full community members and not choose institutional services.
3. Consumers will receive services and supports, prevention and early intervention services within 90 days of the development of their person-centered plan.
4. Consumers will receive a person-centered plan designed to meet the consumer's needs.

The Division of MRDD currently has 3,675 consumers on waiting lists for services. The information listed below identifies the waiting list and number of consumers on the lists:

Waiting Lists as of August 2003	Consumers
1. Residential Services	641
2. Non-Residential Services	2,053
3. Autism Services	961
4. Olmstead Waiting List	20
	3,675

Consumers are currently placed on the Division waiting lists until resources are available to fund the services that are required by their person-centered plans. The state resources available to support the Non-Residential Services and Autism Services, which are typically provided to non-Medicaid eligible children, has been shrinking over the last two budgets. The Division experienced a core reduction in Community Program funding used to purchase services for Non-Medicaid eligible consumers in excess of $7 million over the last two fiscal years 2003 and 2004. These services allow children to stay in their own communities at home with their families. The Division has been unable to support families effectively during these difficult budgetary times.

The Division was unable to authorize any new services except for emergency situations in fiscal year 2003. The Division will continue the process in fiscal year 2004 except for the new

services authorized as a result of the 'Caseload Growth" funds used to reduce waiting lists and purchase emergency services for Medicaid eligible consumers.

In order to serve individuals on the waiting lists within the 90 day requirement of Senate Bill 266, the Division must have the ability to maintain core Community Program funding and increase Community Program funding annually to serve new consumers (Medicaid eligible and Non-Medicaid eligible) determined eligible for Division of MRDD services by the Regional Centers. Approximately 1,200 new consumers are determined eligible for MRDD services each year.

The new decision item in fiscal year 2004 "Caseload Growth" was funded at $5.0 million. These dollars will help the Division address the growing number of Medicaid eligible consumers on the Division waiting lists. The "Caseload Growth" funding, which is based on the Division of Medical Services' annual projection of new Medicaid eligible consumers, must become an integral part of the annual budget request process for the Division. The annual increase to Community Program funding will be necessary to meet the needs of Medicaid eligible consumers on the waiting lists. If the Division is not able to obtain this increase in funding annually, it will be impossible for the Division to be successful in complying with Senate Bill 266.

The Division must also have additional resources for Non-Medicaid eligible consumers on the waiting lists. The Division will continue to request additional state resources to move consumers off of the waiting lists and will continue to redirect funds, identify other generic services and supports in local communities, continue to investigate all funding streams and develop other strategies to meet the needs of consumers.

See Appendix II-8 for details, p.61

APPENDIX

APPENDICES

I **a.** Waiting List MAT Membership
b. Senate Bill 266
c. Waiting Lists in the Division of MRDD

II-1 Five Year Budget Proposal

II-3 **a.** Provider Capacity Survey Letter
b. Provider Capacity Survey Instrument
c. Provider Capacity Survey Results and Provider Comments

II-4 **a.** Utilization Review Policy
b. Utilization Review Checklist
c. Utilization Review Prioritization of Need

II-5 MRDD Division Policy – Criteria for Home and Community Based Waiver Slot Assignment Policy

II-8 Wait List Information – Residential Services / Non Residential Services (Table)
Most Frequently Requested Non-Residential Services (Table)

Appendix I a.

DIVISION OF MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES
WAITING LIST MANAGEMENT ADVISORY TEAM
MEMBER CONTACT LIST

Kent Stalder, Co-Chair
Division of MRDD
South District Deputy

Wendy Buehler, Co-Chair
Life Skills Foundation
Missouri Association of Rehabilitation Facilities

Neva Thurston
Missouri Planning Council

Jennifer Wooldridge, Exec Director
Jefferson County Commission for Handicapped/Developmental Services of Jefferson County

Katie Smallen, President
Missouri Chapter of the American Network of Community Options and Resources (MO-ANCOR)

Becky Dickey
People First of Missouri

Lisa Chomor, Executive Director
Metropolitan Council on Developmental Disabilities

Jim Casey
Cole County Residential Services, INC

Kirstin Dunham
Paraquad

Gail Clair
Division of MRDD
North District Deputy

Jeff Grosvenor
Division of MRDD

Kay Green
Division of MRDD

Richard Strecker
Division of MRDD

Susan Pritchard-Green,
Missouri Planning Council
Division of MRDD

Mary O'Brien
Personal Independence Commission (PIC)

Appendix I b.

FIRST REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED**]**

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 266

92ND GENERAL ASSEMBLY

2003

1024L.02T

AN ACT

To amend chapter 633, RSMo, by adding thereto two new sections relating to services for persons with developmental disabilities.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Chapter 633, RSMo, is amended by adding thereto two new sections, to be known as sections 633.032 and 1, to read as follows:

633.032. 1. The department of mental health shall develop a plan to address the needs of persons who are on a waitlist for services, including persons in habilitation centers waiting for community placement. Such plan shall reflect the partnership between persons with developmental disabilities and their families, community providers, and state officials, and shall support the choice and control of consumers and their families in the delivery of services and supports. Such plan shall include the following:

(1) A method to reduce the waitlist for services over a period of five years and to reduce the waiting period to ninety days;

(2) A description of minimum supports and services available to all eligible individuals and their families;

(3) An evaluation of the capacity of current providers to serve more individuals;

(4) A method of adjusting support and service levels based on the needs of the eligible individual combined with family or other relevant circumstances affecting the support of such individual;

(5) A method for determining the circumstances when out-of-home twenty-four-hour care may be necessary;

(6) A description of how the plan will be implemented on a statewide basis;

(7) Any changes in state law that will be required to implement the plan; and

(8) An analysis of the budgetary and programmatic effects of providing supports and services for all eligible individuals and their families.

2. The plan required pursuant to this section shall be completed on or before November 1, 2003. The director of the department of mental health shall submit a copy of the plan to the speaker of the house of representatives, the president pro tem of the senate, and the governor.

Section 1. 1. The department of mental health and the department of social services shall jointly prepare a plan to address the need for mental health services and supports for:

(1) All of the cases in the custody of the department of social services that involve children in the system due exclusively to a need for mental health services, and where there is no instance of abuse, neglect, or abandonment; and

(2) Children or persons seventeen years of age who are determined by the court to require mental health services under subdivision (5) of subsection 1 of section 211.181, RSMo.

2. Such plan shall include:

(1) An analysis of federal funding, including waivers, that may be used to support the needed mental health services and supports;

(2) An analysis of the budgetary and programmatic impact of meeting the needs of the children and persons seventeen years of age for mental health services and supports; and

(3) An analysis of the feasibility, including time frames, of securing federal funds for the support of the needed mental health services and supports.

3. The plan required in this section shall be completed on or before January 1, 2004. The directors of the department of social services and the department of mental health shall submit a copy of the plan to the governor, the president pro tem of the senate, and the speaker of the house of representatives.

Appendix I c.

Waiting Lists In the Division of MRDD

The term waiting list, or wait list, refers to several tracking systems within the Division of Mental Retardation and Developmental Disabilities. The need for multiple wait lists can cause confusion. Below is a brief listing of the types of requests that we track and a description of a likely outcome for these wait lists, should the plan for implementing Senate Bill 266 be accepted.

Waiting lists are used to track services:

1) Residential services
2) In-home supports

Waiting lists are used to track slot requests:

1) Comprehensive Waiver Slots
2) Community Support Waiver Slots
3) Lopez Waiver Slots

Waiting lists are used for:

1) Olmstead – people asking to leave hab centers
2) Nursing home – people asking to leave nursing homes
3) Hab Center Admissions (emergency only)
4) Autism services through the Autism Projects

In addition, there are county waiting lists for services or admissions to waivers. These county lists should be viewed as sub-sets of the Division list.

Should the Division continue to receive caseload growth funds and other funds requested in this plan, the residential services wait list and the in-home support wait list could be eliminated, except for those new people being added. Those requests would be met within 90 days.

The delivery of services on those lists would eliminate many of the same people waiting to receive a comprehensive waiver slot, or a community support waiver slot. By meeting the needs of those on the residential wait list, we would meet the needs of those on the Olmstead list, waiting to get out of habilitation centers, and those people in nursing homes waiting for community living.

Potentially, after implementation of the plan, we would only have short-term waiting lists and perhaps some people waiting to enter the Lopez Waiver which, as a demonstration waiver, is

limited to 200 slots statewide. Even so, the MRDD needs of those waiting for Lopez could be met with full implementation of the plan.

The Division of MRDD has typically tracked people waiting for residential services using a Priority I, II, and III coding system. For the past year, beginning July 2002, the Division also kept Utilization Review (UR) scores on each request for a service that could not be immediately funded. Regional Centers use the UR score as the criteria for selecting the next service request to be supported.

During the full year that was required for each plan to go through the UR process, we maintained two separate waiting lists for services from July 2002 through July 2003: the priority system in CIMS, and the UR system.

As of July 2003, we could suspend using the outdated priority system. We recommend tracking needed services with the UR process alone.

Appendix II-1

Senate Bill Number 266
633.032 (1) (1) A method to reduce the waitlist for services over a period of five years and to reduce the waiting period to ninety days.

The Division, as of July 1, 2003, maintains approximately 3,675 consumers on a waiting list. A process to reduce the waitlist for services over a five year period is described below. After five years, the waiting period for which consumers are placed on a waiting list must be reduced to less than ninety days before a consumer is able to access appropriate support services.

The following assumptions were made to calculate the anticipated growth of new consumers to the MRDD Service System over the next five years.

1. The Division has historically grown by approximately 1,200 new consumers per year. On average we expect to continue to see the same number of new consumers accessing the MRDD Service System.
2. The Division expects to see more children being diagnosed with autism to enter our system in the years to come. We anticipate this growth based on growing prevalence rates and early diagnosis which will promote early intervention strategies. On average we expect to see at least 200 new consumers per year requesting specialized autism services.
3. Years 4 and 5 of this plan will be completed after the Division has successfully reduced the waiting lists during Years 1 thru 3. The plan for the last two years will be resubmitted for approval after making appropriate adjustments based on the actual data obtained during the first three years of the plan.

Year 1 – Fiscal Year 2004

Funding for Services:	Caseload Growth* (Medicaid) - $5.0 million
Waiting List Reduction:	230 consumers removed from Residential Waiting List
	Caseload Growth* (Non-Medicaid) - $2.0 million
	450 consumers removed from Non-Residential Waiting Lists (Autism, In-Home Services)

Adjusted number of Consumers on Waiting Lists:	2,995
Estimated New Eligible Consumers Added to Waiting Lists:	1,400
Total Consumers Waiting for Services:	4,395

Year 2 – Fiscal Year 2005

Funding for Services:	Caseload Growth* (Medicaid) - $5.0 million
Waiting List Reduction:	200 Medicaid eligible consumers removed from Residential Waiting List 150 Medicaid eligible consumers removed from Non-Residential Waiting List (Autism, In-Home Services)
	Caseload Growth* (Non-Medicaid) - $5.0 million 1,200 consumers removed from Non-Residential Waiting Lists (Autism, In-Home Services)

Adjusted number of Consumers on Waiting Lists:	2,845
Estimated New Eligible Consumers Added to Waiting Lists:	1,400
Total Consumers Waiting for Services:	4,245

Year 3 – Fiscal Year 2006

Funding for Services:	Caseload Growth* (Medicaid) - $7.0 million 50 Medicaid eligible consumers removed from Residential Waiting List 1,350 Medicaid eligible consumers removed from Non-Residential Waiting List (Autism, In-Home Services)
	Caseload Growth* (Non-Medicaid) - $5.0 million 1,200 consumers removed from Non-Residential Waiting Lists (Autism, In-Home Services)

Adjusted number of Consumers on Waiting Lists:	1,645
Estimated New Eligible Consumers Added to Waiting Lists:	1,400
Total Consumers Waiting for Services:	3,045

The plan for Year 4 and Year 5 will be determined after evaluating actual data from Years 1 thru Year 3.

Year 4 – Fiscal Year 2007 @

Funding for Services:	Caseload Growth* (Medicaid) - $7.0 million 50 Medicaid eligible consumers removed from Residential Waiting List 1,350 Medicaid eligible consumers removed from Non-Residential Waiting List (Autism, In-Home Services)

Caseload Growth* (Non-Medicaid) - $5.0 million
1,200 consumers removed from Non-Residential Waiting Lists (Autism, In-Home Services)

Adjusted number of Consumers on Waiting List:	445
Estimated New Eligible Consumers Added to Waiting Lists:	1,400
Total Waiting for Services:	1,845

@ The Year 4 and Year 5 waiting list plans will be revised after evaluating actual data from FY 2006. Necessary adjustments will be made to the plan to eliminate waiting lists by Year 5.

Year 5 – Fiscal Year 2008

Funding for Services:

Caseload Growth* (Medicaid) - $7.0 million
50 Medicaid eligible consumers removed from Residential Waiting List
1,350 Medicaid eligible consumers removed from Non-Residential Waiting List (Autism, In-Home Services)

Caseload Growth* (Non-Medicaid) - $5.0 million
1,200 consumers removed from Non-Residential Waiting Lists (Autism, In-Home Services)

Number of Consumers on Waiting Lists at the end of Year 5: -0-

Year 6 and Ongoing

The Division will continue to be mandated to serve consumers in accordance with Senate Bill 266 with in 90 days. In order to be successful in complying with Senate Bill 266, the Division will need an ongoing source of "Caseload Growth" funds* to be able to provide appropriate support services within 90 days. Placing consumers on a waiting list for over 90 days will not comply with the Senate Bill 266 legislation. The Division will be requesting additional funds during the annual DMH Budget Request cycle to support additional consumers and the Division may need to develop a supplemental budget request for "Caseload Growth" funds* in future years when the number of consumers eligible for services is greater than our available resources.

* "Caseload Growth" funding is subject to appropriations by the General Assembly.

Appendix II-3 a.

July 29, 2003

Dear Director:

As I am sure you are aware, Senate Bill 266 was passed by the Missouri legislature and was signed by the governor. The DMH/MRDD has convened a Wait List MAT in preparation for implementing this legislation. SB266 contains the following provisions:

633.32.1. The Department of Mental Health shall develop a plan to address the needs of persons who are on a wait list for services, including persons in habilitation centers waiting for community placement. Such plan will reflect the partnership between persons with developmental disabilities and their families, community providers, and state officials and shall support the choice and control of consumers and their families in the delivery of services and supports. Such plan shall include the following:

(1) A method to reduce the wait list for services over a period of five years and to reduce the waiting period to 90 days;

(2) A description of minimum supports and services available to all eligible individuals and their families;

(3) **An evaluation of the capacity of current providers to serve more individuals**;

(4) A method of adjusting support and service levels based on the needs of the eligible individual combined with family or other relevant circumstances affecting the support of such individual;

(5) A method for determining the circumstances when out-of-home, 24 hour care may be necessary;

(6) A description of how the plan will be implemented on a statewide basis;

(7) Any changes in state law that will be required to implement the plan; and

(8) An analysis of the budgetary and programmatic effects of providing supports and services for all eligible individuals and their families.

Point three **(3)** requires a survey of all current providers and an evaluation of their ability to expand services to meet the needs of the individuals on the waiting list. This information will be compiled and presented in summary in a report to me. This is not intended to be a

commitment to expand services nor does it limit or oblige any organization. No names of organizations will be used or retained in records.

I appreciate your support and time. This is important in order to plan for the future. Please feel free to contact me if you have any questions. We need your response by August 12, 2003. If you complete the form electronically, please e-mail the results to mzmillb@mail.dmh.state.mo.us. You may also complete a paper form and fax to the attention of B. Miller at (573) 751-9207 or mail to Department of Mental Health, Division of MRDD, 1706 East Elm Street, P.O. Box 680, Jefferson City, Missouri, 65102.

Thank you.

Anne S. Deaton, Division Director
Mental Retardation and Developmental Disabilities

ASD:bjm

Copy: Regional Center Directors
District Deputy Directors

Appendix II-3 b.

SURVEY

PROVIDER CAPACITY

Name of Organization	
Address	
Name of Respondent	
Phone Number	
E-mail Address	
County (Please complete one form for each county in which your organization provides services)	
SAM II Provider Number	
☐ **Send me a Summary of Survey Results**	

Of the following services, which would your organization be willing to expand and if so, approximately how many new people would you be able to serve in the next five years?

Of the following services, which would your organization be willing to expand? Check	**If willing to expand, estimate how many new people you could serve in the next five years?**
☐ **Day Habilitation**	
☐ **Personal Assistance**	
☐ **Respite (out of home)**	
☐ **Respite (in home)**	
☐ **Residential/Community Living**	
☐ **Employment**	
☐ **Transportation**	
☐ **Autism Services**	
☐ **Other**	

If your organization is not willing to expand or develop any of the services listed, please rank the following barriers. The most significant barrier should be ranked number 1 and so forth.

Day Habilitation (Rank order the following with 1 being the most significant)

Barriers					
A		No Interest	F		Staff Training
B		Lack of Expertise	G		Reimbursement Rates
C		Lack of Demand for the Service	H		Transportation
D		Unable to Recruit Qualified Staff	I		Other
E		Worker's Compensation Cost	J		Health Insurance Cost

Personal Assistance (Rank order the following, with 1 being the most significant)

Barriers					
A		No Interest	F		Staff Training
B		Lack of Expertise	G		Reimbursement Rates
C		Lack of Demand for the Service	H		Transportation
D		Unable to Recruit Qualified Staff	I		Other
E		Worker's Compensation Cost	J		Health Insurance Cost

Respite (out of home) (Rank order the following, with 1 being the most significant)

Barriers					
A		No Interest	F		Staff Training
B		Lack of Expertise	G		Reimbursement Rates
C		Lack of Demand for the Service	H		Transportation
D		Unable to Recruit Qualified Staff	I		Other
E		Worker's Compensation Cost	J		Health Insurance Cost

Respite (in home) (Rank order the following, with 1 being the most significant)

Barriers					
A		No Interest	F		Staff Training
B		Lack of Expertise	G		Reimbursement Rates
C		Lack of Demand for the Service	H		Transportation
D		Unable to Recruit Qualified Staff	I		Other
E		Worker's Compensation Cost	J		Health Insurance Cost

Residential/Community Living (Rank order the following, with 1 being the most significant)

Barriers					
A		No Interest	F		Staff Training
B		Lack of Expertise	G		Reimbursement Rates
C		Lack of Demand for the Service	H		Transportation
D		Unable to Recruit Qualified Staff	I		Other
E		Worker's Compensation Cost	J		Health Insurance Cost

Employment (Rank order the following, with 1 being the most significant)

Barriers					
A		No Interest	F		Staff Training
B		Lack of Expertise	G		Reimbursement Rates
C		Lack of Demand for the Service	H		Transportation
D		Unable to Recruit Qualified Staff	I		Other
E		Worker's Compensation Cost	J		Health Insurance Cost

Transportation (Rank order the following, with 1 being the most significant)

Barriers					
A		No Interest	F		Staff Training
B		Lack of Expertise	G		Reimbursement Rates
C		Lack of Demand for the Service	H		Transportation
D		Unable to Recruit Qualified Staff	I		Other
E		Worker's Compensation Cost	J		Health Insurance Cost

Autism (Rank order the following, with 1 being the most significant)

Barriers					
A		No Interest	F		Staff Training
B		Lack of Expertise	G		Reimbursement Rates
C		Lack of Demand for the Service	H		Transportation
D		Unable to Recruit Qualified Staff	I		Other
E		Worker's Compensation Cost	J		Health Insurance Cost

Other (Rank order the following, with 1 being the most significant)

Barriers					
A		No Interest	F		Staff Training
B		Lack of Expertise	G		Reimbursement Rates
C		Lack of Demand for the Service	H		Transportation
D		Unable to Recruit Qualified Staff	I		Other
E		Worker's Compensation Cost	J		Health Insurance Cost

Is your organization willing to expand services into any other counties in Missouri? If so, indicate below and include possible services you could provide?

Include any comments which you believe would be helpful in evaluating the capacity of current providers to serve more individuals.

Appendix II-3 c.

Senate Bill Number 266
633.032 (1) (3) An evaluation of the capacity of current providers to serve more individuals

A survey instrument was developed by members of the DMRDD Wait List MAT. During the first week of August, 2003, the Provider Capacity Survey was sent out to DMRDD providers by the division's eleven regional centers. It is estimated that the survey was sent to 1,300 MRDD contract providers throughout the state. A total of 244 surveys were completed and returned; an 18.76% return rate.

A summary of the survey results follows.

An Evaluation of the Capacity of Current Providers to Serve More Individuals
DMRDD Provider Capacity Survey Results

August 2003

Approximately how many new people would your organization be able to serve in the next five years?

	Total Response
Day habilitation	1674
Personal Assistance	1063
Respite	1597
Residential/community Living	1603
Employment	661
Transportation	404
Autism Services	231
Other	156

If your organization is not willing to expand or develop any of the services listed, rank the following barriers.

Day Habilitation **(Rank order the following with 1 being the most significant)** NR=Not Ranked by any provider

Ranked Day Habilitation Barriers

A	1	**No Interest**	**J**	5	**Health Insurance Cost**
G	2	**Reimbursement Rates**	**F**	6	**Staff Training**
D	3	**Unable to Recruit Qualified Staff**	**C**	7	**Lack of Demand for the Service**
B	4	**Lack of Expertise**	**H**	8	**Transportation**
E	5	**Worker's Compensation Cost**	**I**	9	**Other**

Personal Assistant **(Rank order the following with 1 being the most significant)**

Ranked Personal Assistant Barriers

G	1	**Reimbursement Rates**	**F**	6	**Staff Training**
E	2	**Worker's Compensation Cost**	**H**	6	**Transportation**
J	3	**Health Insurance Cost**	**B**	7	**Lack of Expertise**
C	4	**Lack of Demand for the Service**	**A**	8	**No Interest**
D	5	**Unable to Recruit Qualified Staff**	**I**	9	**Other**

Respite (out of home) **(Rank order the following with 1 being the most significant)**

Ranked Out-of-Home Respite Barriers

E	1	**Worker's Compensation Cost**	**I**	5	**Other**
D	2	**Unable to Recruit Qualified Staff**	**G**	6	**Reimbursement Rates**
J	3	**Health Insurance Cost**	**F**	7	**Staff Training**
C	4	**Lack of Demand for the Service**	**H**	7	**Transportation**
A	5	**No Interest**	**B**	8	**Lack of Expertise**

Respite (in home) **(Rank order the following with 1 being the most significant)**

Ranked In-Home Respite Barriers

A	1	**No Interest**	**F**	6	**Staff Training**
G	2	**Reimbursement Rates**	**C**	7	**Lack of Demand for the Service**
D	3	**Unable to Recruit Qualified Staff**	**H**	8	**Transportation**
E	4	**Worker's Compensation Cost**	**B**	9	**Lack of Expertise**
J	5	**Health Insurance Cost**	**I**	10	**Other**

Residential/Community Living **(Rank order the following with 1 being the most significant)**

Ranked Residential/Community Living Barriers

G	1	**Reimbursement Rates**	**C**	6	**Lack of Demand for the Service**
J	2	**Health Insurance Cost**	**F**	7	**Staff Training**
E	3	**Worker's Compensation Cost**	**H**	8	**Transportation**
D	4	**Unable to Recruit Qualified Staff**	**B**	9	**Lack of Expertise**
I	5	**Other**	**A**	10	**No Interest**

Employment **(Rank order the following with 1 being the most significant)**

Ranked Employment Barriers

D	1	**Unable to Recruit Qualified Staff**	**H**	6	**Transportation**
F	2	**Staff Training**	**A**	NR	**No Interest**
G	3	**Reimbursement Rates**	**B**	NR	**Lack of Expertise**
I	4	**Other**	**C**	NR	**Lack of Demand for the Service**
E	5	**Worker's Compensation Cost**	**J**	NR	**Health Insurance Cost**

Transportation **(Rank order the following with 1 being the most significant)**

Ranked Transportation Barriers

J	1	**Health Insurance Cost**	**C**	NR	**Lack of Demand for the Service**
E	2	**Worker's Compensation Cost**	**D**	NR	**Unable to Recruit Qualified Staff**
G	3	**Reimbursement Rates**	**F**	NR	**Staff Training**
A	NR	**No Interest**	**H**	NR	**Transportation**
B	NR	**Lack of Expertise**	**I**	NR	**Other**

Autism **(Rank order the following with 1 being the most significant)**

Ranked Autism Service Barriers

B	1	**Lack of Expertise**	**E**	NR	**Worker's Compensation Cost**
G	2	**Reimbursement Rates**	**F**	NR	**Staff Training**
A	NR	**No Interest**	**H**	NR	**Transportation**
C	NR	**Lack of Demand for the Service**	**I**	NR	**Other**
D	NR	**Unable to Recruit Qualified Staff**	**J**	NR	**Health Insurance Cost**

Other **(Rank order the following with 1 being the most significant)**

Ranked Other Service Barriers

A	NR	**No Interest**	**F**	NR	**Staff Training**
B	NR	**Lack of Expertise**	**G**	NR	**Reimbursement Rates**
C	NR	**Lack of Demand for the Service**	**H**	NR	**Transportation**
D	NR	**Unable to Recruit Qualified Staff**	**I**	NR	**Other**
E	NR	**Worker's Compensation Cost**	**J**	NR	**Health Insurance Cost**

NR=Not ranked by any providers

PROVIDER CAPACITY SURVEY (Senate Bill 266)

Summary of responses to survey question: Is your organization willing to expand services into any other counties in Missouri?

If so, indicate below and include possible services you could provided?

DEMAND
No guarantees in providing more residents to the facility. Would build more homes if could be given guarantee that residents would be placed. Lack of funding is also a big problem,
We have had so few referrals in the past few years we are happy to serve more people. We would ask you to use current providers to do the new business since our admin. we need additional business to stay in business.
Closed one ISL - still needing three residents to fill homes.
In considering our next HUD development, does DMH need apartments, group homes or other types of residential care facilities?
We have capacity for five and only have four residents but had a very difficult time last year even filling that 4th place when we had a vacancy.
We have the capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have the capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have the capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have the capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have the capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have the capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have to capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have the capacity to admit a much grerater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have the capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have the capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We have the capacity to admit a much greater number of these recipients and would like to be available to meet your needs. We have many workers available and enjoy these clients.
We can provide services if there is sufficient demand at appropriate reimbursement rates. Some individuals require extensive supports and we can support if MRDD will commit appropriate resources.
Our agency has the capacity to serve and expand quickly but we can't fill our current vacancies because we are told there is no placement money available. We get calls from people wanting our services.
We have added two homes in the last three years-added services for five people. The last one was just started in June. We still have one vacancy.
I am currently licensed for two placements but only have one. I have had a bed ready for 2 1/2 years but have not been called. Also, it would take only a phone call to increase capacity to three because I have the room.
Currently I have one residential habilitation opening in ____ Group Home.
At this time, we would require commitment from the state that any development would be supported by the state.
If a provider knows what people need or want and what the regional center will pay to provide services.
Ask the facility directors - give referrals.
Providers and funders must work cooperatively to develop innovative supports and services.
Providing individual/family in-home and community support will help families maintain their child with a disability in the home for a longer period of time. Review annually cost of living increase of the POS rates. Lack of available funding.
Our facility still has beds available. The time we have been in operation we have never been full for more than one month - we now have, as of today, four beds vacant.
It has proven difficult for us to receive referrals. We have on many occasions made contact with manager, etc. but to no avail. We were told there were providers with preference.

It has proven difficult for us to receive referrals. We have on many occasions made contact with managers, etc. but to no avail. We were told there were providers with preference.
It has proven difficult for us to receive referrals. We have on many occasions made contact with managers, etc. but to no avail. We were told there were providers with preference.
Able to serve a larger capacity provided an adequate labor market, consumer demand and adequate funding and support to insure health, safety and the quality of services.
Able to serve a larger capacity provided an adequate labor market, consumer demand and adequate funding and support to insure health, safety and the quality of services.

FUNDING

Determine if a flat fee schedule is preferred over unit cost computations (Schedule developed by state similar to Division of Senior Services and Healthy Children and Youth).
Across the board, a higher direct contact reimbursement and pay rate will help in all of the above areas.
Currently have 10 newly constructed single apartments empty, where funding was promised and has fallen through.
Without regular (annual) rate increases, it is extremely difficult for any business to grow. Without regular rate inceases, agencies cannot absorb those costs.
Need reimbursement rates that reflect real costs. Don't skimp on staff salaries/benefits and hold sacred the funding for staff training.
We need regular and consistent base rate increases to keep up with the continuing rising costs of doing business.
Current ISL reimbursement rates include punitive "cap" on admin. Reimbursement. This financially punishes agencies for providing 24-hour ISL services.
Only if reimbursement rates were such to make recruitment of well qualified staff possible and still be able to break even.
Due to current financial status, we will do good to keep status quo.
Current funding for residential care is below the actual cost of housing, medical and protective oversight.
I think it's a lack of funding from the state to provide services for individuals with MRDD. I've had an opening for over a year and a half.
Cost must be covered.
Funding is, of course, always an issue. I have one ISL home in Fulton for deaf-MR clients and I get frequent calls about other deaf clients needing services.
We provided respite day care for one individual for three months. Family hasn't paid their balance at this time.
The agency has to carry the cost of a minimum of six weeks of salaries for the employees. Background screening and training is never reimbursed.
Our capacity to grow is largely dictated by cash flow. There are no mechanisms to provide an agency with capital to start new services. .
Our biggest probem is getting good help because our reimbursement rate does not allow us to pay as much as other companies.
Our biggest problem is getting good help because our reimbursement rate does not allow us to pay as much as other companies.
Our biggest problem is getting good help because our reimbursement rate does not allow us to pay as much as other companies.
Our biggest problem is getting good help because our reimbursement rate does not allow us to pay as much as other companies.
More funding for ISL's - contact directors.
Contact directors/open ISL funding.
Our rates will have to increase so we can hire qualified staff and pay them enough money to live on.
Funding is the main obstacle to expansion.
Expansion or change in services will require a review of current rates. Providers must receive annual cost of living adjustments.
Reimbursement rates to allow for qualified staff to be hired to insure quality service to consumers.
Salaries and insurance cost benefits are imperative to recruiting qualified staff and retaining staff.
Our pay is so low it is difficult to hire and retain people. Once we have hired good staff - having the money to train properly is also a barrier.
In expanding our services, we would need to be compensated for these expanded services at least enough to cover the added expenses

INSURANCE

The amount of people that could be served depends on the ability to get qualified staff, and if vendors could offer a health insurance plan.
Offering some general coverage for liability.
The biggest barrier we have is the cost of health insurance for our full-time employees.

OTHER

If there was a way to ensure that the providers are notified equally.
If there was a way to ensure that the providers are notified equally.
Evaluate how the provider currently supports individuals - both consumers and their staff. Don't allow an agency to expand if they are not doing their best now.
Implement sign language as a choice for those who use it or can be taught to use it to communicate in their environment, either hearing with no voice skill or deaf.
I am unsure of what our "SAM II Provider Number" is?
We want to encourage other providers to create options for persons in Franklin County. We will encourage others to develop needed services.
No comment at this time.
We provide wheelchair accessible vehicle conversions and repairs. I don't see how this survey applies to us.
I'm looking to buy a five bedroom home to house up to at least 6-8 individuals and fully operated by staff to run the home. This is my goal.
Remove "cap" that DMH places on RCF's. We are a 94 bed RCF but allowed a maximum of 30 DMH clients. We have 40 available beds.
We are limited as an SB 40 county to vocational and residential expenditures. This is a big barrier for us.
Unable to expand or provide these services.
We have long requested to be able to use our on-site apartments (#4) for ISL; however, have been denied as it is felt there would be "too many clients" at one site.
We are able to provide increased services now. The amount of documentation required in order to provide services could be more supportive if streamlined/reduced.
I would like to provide service care to more clients but I need a larger home to do so. Would also like to have another van. Yes, I would like to expand to a larger group home or ISL.
Do not feel we are candidate to expand since we are a skilled nursing facility.
Ste. Genevieve is a county that has few qualified people willing to be employed to serve persons with disabilities.
Better communication between regional center and providers. More honest and professional service coordinators. More provider training.
Better communication between Regional Center and providers. More honest and professional service coordinators. More provider training.
We are willing to expand and recruit and train. The workforce in Benton County is plentiful.

Appendix II-4 a. **Utilization Review Process**

The purpose of the Utilization Review/Approval Process is to:

- stretch limited MRDD resources;
- ensure accountability for taxpayer dollars; and
- ensure fairness and consistency statewide.
- enhance quality of services and the service delivery system

Utilization Review Committee: In Home and Residential

The Core Committee may consist of the following: Quality Assurance Representative, Parent Policy Partner, Community Resource Specialist, Business Office Representative, Service Coordination Representative, Administrative Representative. A minimum of three members from the Core Committee is necessary to meet, however the Division encourages Regional Center Review Committees to have a full, active, and involved membership. The service coordinator for the plan being reviewed is encouraged to attend, but cannot be considered a core UR committee member for that plan.

The Committee shall meet a minimum of once per week.

During the first year all plans with funds that process through the Department of Mental Health shall be reviewed. After the first year of implementation, the Committee shall review all initial plans/budgets with funds, amended plans that raise the dollar amounts, plans that add new services, and plans at the discretion of the local UR Committee. Plans/budgets will be sampled for review in all stratified levels. Other personal plan reviews will continue to be completed by the service coordinator and/or service coordination supervisor, as directed by the Regional Center Director.

The Committee shall use the approved Utilization Review Checklist to assist in the review and approval of budgets.

If the Committee approves a budget, the Committee chairperson will sign off and forward to the Center Director or Designee for final review and approval of all budgets.

Upon approval by the Center Director/designee, all MCFDS budgets above $5,000 will be forwarded to the District Deputy for final approval. At the discretion of the Regional Center Director or District Deputy Director, residential service plans may be forwarded to the district or state level for review.

If not approved at any level, the budget and the Utilization Review Committee Recommendations Form will be returned to the appropriate Service Coordinator within 3 working days. This form indicates what, if any, plan of action should be taken before the budget can be approved. If indicated, the service coordinator must respond to the Committee, Director/Designee, or District Deputy in writing within 10 working days of the utilization review.

The Service Coordinator is responsible to keep the individual/family informed during the utilization review process, including the final approval status of the plan/budget.

No new services/supports will begin before the budget is approved.

Utilization review levels for MCFDS budgets are determined by the total cost of all services/supports paid through DMH billing system—including DMH funds, SB40 waiver and non-waiver match, and Medicaid Waiver match dollars. "Family", "Community Partner" and "Other System" dollars are not included.

Once a budget is approved via the established utilization review/approval process, any request for additional funds must be added to the approved budget (the total cost of all services/supports—including DMH, SB40 waiver and non-waiver match, and Medicaid Waiver match dollars) to determine the new utilization review level. The additional request may not be considered in isolation of other services/supports the individual and family is receiving.

Review/Approval Levels: Applies to In Home Services/Supports Only

I. Local (Regional Center) Approval	**Up to $5,000**
II. District (Deputy) Approval Children (up to age 18 *or* thru age 21 if still in school) Adults (age 18 and over *or* after graduation) **Budgets may be passed on to the State Review Committee at the Deputy's discretion.	**$5,001 to $10,000** **$5,001 to $18,500**
III. Statewide (Budget Review Committee) Approval Children (up to age 18 *or* thru age 21 if still in school) Adults (age 18 and over *or* after graduation)	**Over $10,000** **Over $18,500**

It should be understood that when plans are developed for partial year budgets, the cost should be annualized to determine the appropriate UR level.

When there are multiple family members who receive services, it should be noted and all of the budgets considered together in the UR process. In order to make a determination of what level of services is appropriate, it is often helpful to have a comprehensive picture of all services/supports going into a single home. This does not mean they all have to be on the same plan year, but that all of the current supports should be considered.

Applicable Medicaid State Plan services must be accessed first when those state services will meet the person's needs.

If, at any level of the utilization review process, an adverse action* is recommended, the person must 1) be informed in writing at least 10 days in advance of the adverse action; 2) be given the reason for the action; 3) be given information on his/her appeal rights.

*Services may not be denied, terminated or reduced for waiver participants based solely on lack of Regional Center funds.

Appendix II-4 b. **UTILIZATION REVIEW CHECKLIST**

REGIONAL CENTER _____ DATE OF REVIEW _____

Consumer Name:_____ Case #:_____

Age:_____ URL Total $_____ 1st year____ Annual____ Last year URL $_____

Additional Information:_____
_____

PLANNING

_____ Does the plan document the need for each service/support?

_____ Are clear outcomes identified for each service/support?

_____ Have needs been prioritized by the person/family?

_____ How long has this level of support been in place?

_____ Has progress toward the stated outcomes been achieved?

_____ Has the person applied for Medicaid? If ineligible, why? _____

_____ If the person is Medicaid eligible, have applicable state plan services been accessed that meet the needs? (For persons under age 21, this includes all Healthy Children & Youth Services, OT, PT, and speech therapies, most adaptive equipment, diapers, and personal care that meet the state plan definition. For adults, this includes personal care provided through Department of Health and Senior Services.)

_____ For children, are any services/supports requested the responsibility of the local school district? (The Division cannot supplant services/supports that should be provided by local school districts. The plan should note therapies the child is receiving at school, including frequency, intensity and duration.)

_____ If additional therapies are educationally necessary, have they been pursued through the IEP process?)

FINANCIAL

Where applicable:

_____ Are prescriptions or recommendations for therapies, equipment, etc., attached?

_____ Are bids attached?

_____ **Is the budget page completed, including frequency and rates? Is the math correct?**

_____ **Were there services last year which were authorized and not invoiced? If not, why?**
_____
_____
_____

_____ **Did last year's authorizations/expenditures match the approved budget?**

_____ **Are cost projections reasonable based on ongoing service needs?**

_____ **Is the MRDD funding source noted?** (Waiver, POS, Choices)

_____ **Are all expenditures within the program/service cap?** (ABA $5,000; Environmental Accessibility Adaptations (Home Modifications) $5,000; Choices $3,600; Specialized Medical Equipment and Supplies (Adaptive Equipment) $5,000)

_____**Are there contracts with providers who are receiving over $3000 per year?**

_____**If there is a request for adaptive equipment (for example), does the plan identify the specific equipment/supplies needed, and the justification for each?** (It is not acceptable to approve "up to" the cap for a program service without justification.) **Have we looked for other services?**

_____ **Is there a redirection of funds involved?** (Do health and safety needs justify redirection?)

MISSOURI VALUES

_____ **Is the service a** NEED **rather than a** WANT? **What would happen without the service?** (Is this for maintenance of independent living, prevention from moving to a more restrictive setting, proactive prevention of a potentially abusive situation, etc.?)

_____
_____

_____ **Does the service facilitate a typical lifestyle vs. fostering dependence on the system?**

_____ **Is the amount of support based on the level of need?**

_____ **Have natural supports or other ways to meet the need been obtained first?**

_____ **Is the service/support something that families do not typically provide?**

_____ **Would Missouri taxpayers agree service/support should be purchased with state tax dollars?**

RESIDENTIAL

_____Is this a single person ISL? If yes, why?_____
_____

_____Is the Administration fee limited to 15% or $500 maximum?

_____Are room and board costs within the financial means of the individuals living in the home?

_____Are there any additional services, equipment or supplies in the budget and are they justified with outcomes in the personal plan?

_____Are there asleep, awake, or no overnight staff? (circle one)

_____Are the hours of paid support (for example, ISL, Day Hab, Employment) limited to 24 hours per day?

_____Are there other issues of concern?
_____
_____

_____ _____
Utilization Review Committee Representative Date

Appendix II-4 c.

PRIORITIZATION OF NEED
For Services/Supports

_____Residential **_____In-Home Support**

Consumer Name:_____ Case #:_____

Service Coordinator:_____ Date Placed on Waiting List:_____

Service #1 Category/Points:_____

Service #2 Category/Points:_____

Service #3 Category/Points:_____

Additional Information:_____

Date Scored:_____ URC Representative:_____

In order to be on the prioritized waiting list for services/supports, the service/support *must be:*

- **identified as a need in a person-centered plan;**
- **specifically related to the person's disability (i.e., not something that would be needed regardless of the person's disability); and**
- **unavailable through natural support systems or other funding sources.**

First, read through the five categories, then:

- **pick the category that best describes each service need of the individual.**
- **Only one category can be selected per service. Prioritize this decision based on the service/support (*not* by person).**
- **Once a category has been selected, only compile the points for the selected category for each service.**
- **When the category points are tallied, transfer category number and the total points to the top of this page.**

A service can only be prioritized or listed under one category, however, there can be more than one service in any category.

Points	***CATEGORY I: Health and Safety (5 to 12 points)***
_____	5 pts. **The service/support is necessary to ensure the health and safety of the person or others, i.e., not providing the service/support will place the person or others at risk of illness, injury, or harm.** **In order to be categorized as a health and safety need, the degree of risk must be probable - greater than 50% chance without intervention.**
_____	**Add 1 point (+1 pt.) if degree of risk is imminent—definite and immediate.**

_____	**Add 2 points (+2 pt.) if person has no physical residence (homeless).**
_____	**Add points (maximum of 4) based on Physical/Behavioral Support Checklists. (pg. 3)**
	Cumulative points for Category I. (Not to exceed 12)
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____

Points	***CATEGORY II: Daily Living Supports (4 to 6 points)***
_____	4 pts. **The service/support is necessary to help the person** perform activities of daily living, **e.g., communication, mobility, self-care, etc.** or **to assist an individual with** independent living **or developing the skills necessary to do so. Examples include personal assistance, supported employment, habilitation training, therapy services (including Applied Behavior Analysis), specialized medical equipment and supplies, and environmental accessibility adaptations.**
_____	**Add points if the person currently lives independently (i.e., is not receiving residential services, including ISL), and is** at risk of moving to a more restrictive setting **without the service/support requested.** **+ 2 pts. Immediate (within 30 days)** **+ 1 pt. Prospective (likely within 1 year)**
	Cumulative points for Category II. (Not to exceed 6)
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____

Points	***CATEGORY III: Family Support (3 to 10 points)***
_____	3 pts. **The service/support is necessary to help the family care for their family member in their home** or **family support is not available.**
_____	**Add points (maximum of 4) based on Physical/Behavioral Support Checklists. (pg. 3)**
_____	**Add points (maximum of 3) for other family circumstances. Mark as many as applicable to get a full picture of the family need, however, can only add 3 points.** **___ + 3 pts. Death of primary caregiver.** **___ + 3 pts. Primary caregiver has a terminal diagnosis.** **___ + 2 pts. Primary caregiver has other chronic health conditions that significantly impact his/her ability to provide needed supports for the person.** **___ + 2 pts. Primary caregiver over age 75** **___ + 1 pt. Primary caregiver over age 65** **___ + 1 pt. Single parent family** **___ + 1 pt. Recent (within past 6 mos.) divorce or separation** **___ + 1 pt. More than one family member eligible for MRDD services** **___ + 1 pt. At least 3 children under the age of 10 living in the home** **___ + 1 pt. Recent (within past 6 mos.), unplanned loss of employment**

	Cumulative points for Category III. (Not to exceed 10)
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____

Points	***CATEGORY IV: Inclusion and/or Recreational Supports*** *(In-Home Supports Only)*
	2 pts. **Service/support is necessary to address barriers that might keep the person from** fully participating in his/her community and/or recreational activities.
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____

There are no other contributors to Category IV.

Points	***CATEGORY V: Long Term Planning: This category is either 2 pts <u>OR</u> 1 pt***
	2 pts. **Person is receiving residential services from an alternative funding source (DFS or DMH-CPS). Current residential situation has a time limitation or age restriction and the person has no natural home in which to return** or **persons are receiving residential services from DMH but needs enhanced or alternative services** **OR** 1 pt **Family has long term planning needs... for example, knows that they want placement sometime in the future.**
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____
_____	**Service:**_____ **Frequency:**_____ **Cost:**_____

There are no other contributors to Category V.

Complete both sections on this page as pertains to either Category I or III:

- **Check every applicable event to create a clear picture of the situation.**
- **A maximum of 2 points from each section can be allocated to the category, for a total of 4 points, even though more may apply.**
- **If there is only 1 contributing point in Section One, but three or more points in Section Two, you cannot count a total of 4 points. Only 2 points per section.**
- **When the checklist points are tallied, transfer total points to appropriate category.**
- **Unless otherwise noted, the behavioral or physical need identified must have occurred within the last year.**

Points	BEHAVIORAL SUPPORTS CHECKLIST
_____ 2pt max.	___ +1 pt. Made threats verbally and/or physically(with reasonable threat of physical harm) ___ +1 pt. Destroyed property ___ +1 pt. Ran away (elopement) ___ +1 pt. Abused alcohol and/or substances ___ +1 pt. 2 or more medications used to treat mental illness and/or for behavioral control ___ +2 pts. Harmed him or herself ___ +2 pts. Harmed others (includes animals) ___ +2 pts. Ingested toxic and/or non-food substances or dangerous food quantities ___ +2 pts. Made a suicide attempt or threat ___ +2 pts. Set fires ___ +2 pts. Been sexually aggressive. ___ +2 pts. Physical restraint used in last 6 months

Points	PHYSICAL SUPPORTS CHECKLIST
_____ 2pt max.	___ +1 pt. Chronic pain ___ +1 pt. Significant weight loss or gain (5% of body weight within last 30 days or 10% within last 6 months) ___ +2 pts. Frequent illnesses that interfere with the person and family's daily routines ___ +2 pts. Frequent injuries and/or falls that require medical attention ___ +2 pts. Seizures—frequent and uncontrolled and/or that required emergency hospitalization within the last year ___ +2 pts. Suctioning, tracheotomy, oxygen therapy, ventilator ___ +2 pts. Choking/choking precautions ___ +2 pts. Tube feeding and/or spoon feeding by caregiver ___ +2 pts. Incontinence; daily catheterization and/or bowel care ___ +2 pts. Person requires lifting for transfer that is difficult for caregiver(s) ___ +2 pts. Orthopedic conditions—scoliosis, hip dysplasia, contractures, etc. ___ +2 pts. Skin breakdowns

_____ **Total points of both categories that can be allocated to chosen category. Not to exceed 4.**

Appendix II-5

Division of Mental Retardation and Developmental Disabilities

Division Directive Number 5.020
Effective Date: July, 2002

Anne S. Deaton, Ed.D.,

Title: Criteria for Home and Community Based Waiver Slot Assignment

Application: Applies to Division of MR/DD

Purpose: To prescribe the process by which MR/DD Home and Community Based Waiver slots will be assigned to individuals requesting Waiver services.

I. Regional Center Requests for Slots:

Persons in an emergency situation who require residential services will receive priority consideration in accessing a waiver slot. Division treatment professionals must determine:

1) a community living arrangement is appropriate for that person;
2) the person is eligible for the waiver; and
3) the person chooses waiver services over institutional services

Additionally, the Division's Utilization Review Process, including prioritization of service need (point count) must be applied to all individuals prior to assignment of a slot.

Persons in emergency status might not be on a waiting list at the time the emergency situation arises. However, they must be added to the waiting list, even if the date added and date taken off is the same date. Emergency situation is described as follows:

1) The consumer is in immediate need of life-sustaining services and there is no alternative to Division funding or provision of those services. Life-sustaining service is defined as a service to meet a basic human need, such as food and shelter, or protection from harm. Includes persons referred by CPS with forensic status.
2) The consumer must be provided immediate services in order to protect another person or persons from imminent physical harm.
3) The consumer is residing in an ICF/MR and has been assessed as able to live in the community, the person wants to live in the community, and appropriate services and supports can be arranged through the waiver (Olmstead).

4) The consumer is the focus of a Court order (or imminent Court order) and the Division is obligated to respond.
5) The consumer under age 18 requires coordinated services through several agencies (System of Care) to avoid Court action.
6) The consumer is in the CPS service system (includes children, youth and adults), has a condition other than mental illness only, and requires waiver services to avoid institutionalization (Olmstead).
7) Persons who have been receiving services through the Lopez Waiver who attain age 18, and still require substantial waiver services. (Does not include persons with significant medical needs such as private duty nursing who have an opportunity to be served in the Physically Disabled Waiver and would be better served through that waiver).

II. Senate Bill 40 County Board Requests for Slots:

The District Deputy may consider and may approve requests for slots from Senate Bill 40 County Boards for persons for whom the Senate Bill 40 County Board will fund residential services for persons for whom Utilization Review has been applied and whose need meets emergency criteria.

Requests from Senate Bill 40 County Boards for slots for persons for whom they will fund limited, non-residential services may be considered after a third MRDD capped waiver is approved. (Approval is expected by January, 2003).

III. Process for Requesting Slots

Effective July 1, 2002, all requests for waiver slots must be considered and approved by a Division District Deputy Director, in coordination with the Federal Programs Unit.

1) Regional centers needing slots for emergency situations must forward their request to their Deputy Director, along with the results for the consumer of Utilization Review including prioritization of service need and any other pertinent information regarding the need for a slot. The request to the District Deputy Director must be made through the Regional Center Director or his/her designee to ensure the Regional Center Director is aware and agrees there is an emergency need.
2) The District Deputy Director will consider the request and may approve requests that meet emergency criteria within his/her district as long as funding is available within the district. Regional Center funds will be utilized when available. If the Regional Center does not have funds, the District Deputy will look to the District pool for funding. (District emergency service pool is new for FY 2003. One percent (1%) was withheld from each Region's allocation). If the District pool is depleted, the District Deputy will contact the other two District Deputies and request funding assistance.
3) The District Deputy will work with the Regional Center Director to match the person with any available provider in the state, or the region, considering the family's request.

Each District Deputy Director is responsible for maintaining a log of action taken (approved/denied) on each slot requested, including the criteria the request did or did not meet. (Example, type of emergency need or reason does not meet emergency criteria, other reason for action.) This log will be shared monthly (or as requested) with the other two District Deputy Directors to ensure consistent decisions are being made.

4) Requests from Regional Center Directors must be responded to within 48 hours by the District Deputy Director.
5) When a District Deputy Director approves that a request meets the criteria and is needed, the District Deputy Director will coordinate with the Federal Programs Unit to ensure a slot is available. The Federal Programs Unit will notify the Regional Center Director and the District Deputy Director of final approval within 48 hours of the request from the District Deputy. Waiver services may not start prior to date of final approval. Any services that start prior to approval will be funded with General Revenue.

IV. Processing Requests for Waiver Participation for Consumers Who Do Not Meet Criteria for Emergency Need

Anytime a consumer or the consumer's legal representative requests participation in the MRDD waiver, the Regional Center must determine if the person is eligible for the waiver and if so, if the person wants to participate in the waiver. This includes completing the ICF/MR Level of Care form.

If the person is determined eligible, but the Utilization Review process, including the prioritization of service need has not been done, the Regional Center must complete this process. If the person is eligible, but does not meet the emergency criteria need, the person's name will be placed on a waiver waiting list. Persons on the waiting list will be served according to priority need score.

Send written notification of the results of the eligibility determination to the consumer/legal representative that includes appeal rights regardless of whether the person is determined eligible and placed on a waiting list or is determined ineligible for the waiver. Sample letters are available.

1) Crisis Intervention Services:
   a) If a person requires crisis intervention services and the person is not in the waiver, the previous policy of enrolling the person in the waiver temporarily while the crisis intervention services are needed must end. The process for accessing waiver slots must be the same for all persons. That is, the person must meet residential and emergency criteria.
   b) If a person has been assigned a waiver slot and the person requires crisis intervention services through the waiver, the service may be authorized.

2) Waiver Turnover:
   a) When a person leaves the waiver, funding which that person had been accessing is generally "freed up". Funds that are freed up due to turnover will be used to meet an emergency need. If there is not an emergency need in the region, district or state, the funds may be used to serve a person on the waiver waiting list with the highest rated priority.
   b) Turnover in a two or three person ISL may result in no funds that can be redirected if the same level of staffing must be maintained for one less person. (That is, the cost for the remaining resident(s) increases). When an opening occurs in such a living arrangement, the Regional Center will determine if there is a person in the region, district, or state that meets emergency criteria who chooses this living arrangement (including location) and the current residents choose the individual being referred. If the arrangement is not acceptable to persons meeting emergency criteria, the Regional Center will determine if the living arrangement is acceptable and appropriate for anyone on a waiver waiting list. If it is not, then the Regional Center may request the waiver slot be used for someone in the Region or District according to priority who is otherwise waiting for the service.

V. Resolution of Emergency Situations for Persons With Waiver Slots

1) Once a person is assigned a waiver slot, the slot follows the person, When a person moves from one Region to another, the person keeps the slot. The two Regional Centers will resolve funding issues.
2) The Regional Center Director can immediately resolve emergency situations for persons who have an assigned waiver slot without obtaining approval from the District Deputy Director.

VI. Terminating Waiver Participation

Persons must be terminated from the waiver if they are determined to no longer require ICF/MR level of care, no longer require waiver services, voluntarily discharge from waiver services, become ineligible for Medicaid, move from the State, die, refuse services, or have not received any waiver services for several months. Each person who is terminated must be notified in writing of the action, effective date, and appeal rights. Regional Centers must report the effective date specified on the written notification to the person in Central Office who is responsible for tracking slots statewide.

Send a copy of the letter of notification to the Federal Programs Unit in Central Office. The slot may be reused after 30 days if NO appeal is filed. After 30 days, the Regional Center must notify Central Office Federal Programs Unit staff that an appeal has or has not been filed.

Appendix II-8

Division of Mental Retardation and Developmental Disabilities

State Wide Report of Residential Prioritization of Need

October 3, 2003

	Residential			In-Home Services		
	Medicaid Eligible	Not Currently Enrolled in Medicaid	Total	Medicaid Eligible	Not Currently Enrolled in Medicaid	Total
Albany RC	2	6	**8**	16	107	123
Kirksville RC	3	10	**13**	6	31	37
Hannibal RC	8	23	**31**	6	49	55
Kansas City RC	22	57	**79**	54	653	707
Joplin RC	10	10	**20**	0	22	22
Springfield RC	20	43	**63**	13	142	155
Rolla RC	2	5	**7**	5	30	35
Poplar Bluff RC	2	3	**5**	9	61	70
Sikeston RC	5	3	**8**	7	89	96
St Louis RC	33	104	**137**	40	644	684
Central Mo RC	3	9	**12**	8	88	96
State Wide Total	**110**	**273**	**383**	**164**	**1916**	**2080**

Information based on Excel spreadsheets submitted by the regional centers. Medicaid eligibility determined by the MEIS system on DMH data warehouse. Only those who have been deemed eligible in the last six months, have been included in the Medicaid counts.

In addition, there are 559 individuals/families who have long term planning needs that include residential services.

Appendix II-8 MRDD Most Frequently Requested Services on Waiting List/Non-Residential												
	St Louis	KC	Albany	Cen MO	Hannibal	Kirksville	Joplin	Springfield	Rolla	Poplar Bluff	Sikeston	**Totals**
ABA							1					**1**
Adaptive clothing						3						**3**
Adaptive Equipment	10	2	1	4		6		5		1	1	**30**
Aquatic Therapy				1								**1**
Auditory Integration					5							**5**
Autism Services	1			4	3							**8**
Behavior Therapy	11	17	4									**32**
Behavior Therapy Consultation		3										**3**
Conference								1				**1**
Counseling	1		1			2		1				**5**
Day Habilitation /Community Integration	11	8	6	13	8	21	6	14	1	20	13	**121**
Dental	1											**1**
Dietary Supplements/Vitamins	1	1	1				5	8			1	**17**
Home Modification	6	3		1		3						**13**
Horseback Therapy			1	1			1				1	**4**
Medical Supplies	6	2	4	5			1		4			**22**
Nursing											1	**1**
Nutritional Evaluation				1								**1**
Parent Caregiver Training	16	2	2						8			**28**
Personal Assistant	3	23	3	8	16	1	6	3		2	6	**71**
Psychological Evaluation								1				**1**
Respite / Family Friend	4	37	27	28	4	10	8	38	18	27	10	**211**
Sexuality Training					8							**8**
Supported Employment				3		1						**4**
Swim Safety course								1				**1**
Ther Rec Camp	1											**1**
Therapy PT, OT, speech	2	1		2				2			2	**9**
Transportation	12	1		3	6	3						**25**
Sample Size	**86**	**100**	**50**	**74**	**50**	**50**	**28**	**74**	**31**	**50**	**35**	**628**